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FOR STATE  
HEALTH DEPT. **M**

TO BE COMPLETED BY THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it may be executed by the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH <b>05466</b>												
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY in lb <b>19yrs. 2mo. 9days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>158 Bowery</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>C.</b> Last <b>BRODE</b>						4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1961</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-92</b>		9. AGE (In years and birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Andrew Brode</b>						14. MOTHER'S MAIDEN NAME <b>Jeanette Hill</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Ruptured abdominal aorta.</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>451X</b> (b) <b>2. Arteriosclerotic aneurysm, aorta.</b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>10-15 min.</b>  <b>Unknown</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>R. C. DODSON</b> EXAMINER'S NAME (Type) <b>R. C. DODSON</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						DATE SIGNED <b>5-22-61</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>						22b. DATE THEREOF <b>5/25/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR <b>Pennington &amp; Son, Havre de Grace, Md.</b>						24a. REC'D BY REGISTRAR <b>MAY 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, the Medical Examiner may execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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I

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5476

05467

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN lb 30 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 231 E. High Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER J. BRYSON				4. DATE OF DEATH Month Day Year May 1, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1882	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Bryson				14. MOTHER'S MAIDEN NAME Dilks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 17. INFORMANT Leroy J. Bryson, New Castle, Delaware.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 Acute Coronary occlusion DUE TO (b) Cardiac Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 5 min. 2 yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. DODSON, M.D.				DATE SIGNED 5-2-61			
EXAMINER'S NAME (Type) R. C. DODSON, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-61		22c. NAME OF CEMETERY OR CREMATORY North East Meth. Cem.		22d. LOCATION (City, town, or country) (State) North East, Md.	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME Donald M. Due Elkton, Md.				24a. REC'D BY REGISTRAR MAY 5 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

FOR FILE  
IN 100-100000

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FOR STATE  
HEALTH DEPT.

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director, or his designee, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME  
5M 9/60

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5477											
05468											
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Rural Life</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Rural</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Clendenin Mill</b>						d. STREET ADDRESS <b>Old Clendenin Mill</b>					
3. NAME OF DECEASED (Type or print) <b>JAMES ROE CALDWELL</b>						4. DATE OF DEATH <b>May 7, 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-22-1921</b>		9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Caldwell</b>						14. MOTHER'S MAIDEN NAME <b>Mary Sexton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> (If yes, give war or dates of service) <b>World War 1917-14-3265</b>						16. SOCIAL SECURITY NO. <b>Mrs. Ethel Caldwell Colora Md. R.F.D.</b>					
17. INFORMANT <b>Address</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest, heart and aorta</b>											
981X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by unknown assailant</b>					
20c. TIME OF INJURY <b>5:00 a.m.</b>		Month, Day, Year <b>5/7 1961</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mill</b>		20f. (City or town) <b>Colora</b>		(County) <b>Cecil</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> end in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Russell S. Fisher</b>						DATE SIGNED <b>5/8/61</b>					
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>5-15-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conowingo Cem.</b>		22d. LOCATION (City, town, or country) <b>Conowingo Md.</b>	
23. FUNERAL DIRECTOR <b>Terrence McMillen</b>						ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



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TO DEPARTMENTAL MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <b>Cecil</b> <b>MARYLAND</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>								d. STREET ADDRESS <b>Warwick</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Edward Carroll</b>								4. DATE OF DEATH Month Day Year <b>5 11 1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-23-1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Carroll</b>						14. MOTHER'S MAIDEN NAME <b>Sarrah Jane Hover</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>218-14-6477</b>		17. INFORMANT Address <b>Michael Carroll, Warwick, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. DUE TO (c) }										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>5-11-61</b>			
EXAMINER'S NAME (Type) <b>R.C. Dodson MD, Rising Sun, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 15, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Bohemia Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Warwick, Md.</b>			
23. FUNERAL DIRECTOR ADDRESS <b>B. Lester Daniels Middlebrook, Delaware</b>						24a. REC'D BY REGISTRAR DATE <b>MAY 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hanes</b>			



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Union Hospital

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U.S.A.

Michael Carol

Sarah Jane Hovey

yes W.W.I

218-1-6477

Michael Carol, Warwick, Ms.

Acute coronary Occlusion

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R.J. Dodson MD, Rising Sun, Md.

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2-11-01

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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05470

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u> c. LENGTH OF STAY IN lb <u>59 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, USNTC</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> d. STREET ADDRESS <u>211-D Laffey Circle, Manor Heights</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Eugene Paul CHIARI, Jr.</u>		<b>4. DATE OF DEATH</b> Last <u>May</u> Month <u>13</u> Day <u>1961</u>													
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Caucasian</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 12 1961</u>												
<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td><u>59</u></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				<u>59</u>	<b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>Cecil County, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
			<u>59</u>												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>													
<b>13. FATHER'S NAME</b> <u>Eugene Paul CHIARI</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Teresa (n) McGINN</u>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>													
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>Address</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEONATAL ANOXIA</u> DUE TO (b) <u>CORD FACTOR (True knot and loop about neck)</u> DUE TO (c) <u>7610</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>59 minutes</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>9:15 PM</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)												
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 13 1961</u> <b>to</b> <u>May 13 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 13 1961</u> , <b>and that death occurred at</b> <u>9:15 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Paul C Horn</u>		<b>22b. DATE SIGNED</b> <u>5-15-61</u>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>PAUL C. HORN LT MC USNR</u>		<b>22d. ADDRESS</b> <u>Station Hospital</u> <u>U.S. Naval Training Center, Bainbridge, Md.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>5-16-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>West Nottingham Cemetery</u>	<b>23d. LOCATION (City, town or county)</b> (State) <u>Colora, Cecil Co, Maryland</u>												
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee A. Patterson &amp; Son</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAY 17 '61</u>													
<b>ADDRESS</b> <u>PERRYVILLE, MARYLAND</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Robert E. K...</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60



Geoff  
Bridges

Section Hospital, UNITO

Maryland  
Port Deposit  
50 minutes

211-D Valley Circle, Port Deposit

Supervisors

CHARTER

May

May 13 1961

Male

Geoff County, Maryland  
U. S. A.

Ammonia Fuel CHARTER

Teressa (A) MORTON

Hospital Records

RESTATEMENT

CURD FACTOR (Time food and food about noon)

50 minutes

May 13 61

May 13 61

May 13 61

RAUN, C. ROSE AT NO USER

U.S. Naval Training Center, Port Deposit, MD.

the Washington Company, Colonel, Geoff Co., Maryland

THE A. PATTERSON & SONS, FARMINGTON, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5480

05471

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CECIL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b> c. LENGTH OF STAY IN 1b <b>15yrs4mos28days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>ALLEGHENY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PITTSBURGH</b> d. STREET ADDRESS <b>1707 CONCORDIA</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOSEPH DANIEL CZOLBA</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>13</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 15, 1897</b>
<b>9. AGE</b> (In years by birthday) <b>64</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>7</b> Days <b>5</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PENNA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>ADAM CZOLBA</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>JOSEPHINE LEWANDASKI</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW-1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	
<b>17. INFORMANT</b> Address <b>Hospital Records, VAH., Perry Point, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>420.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Aneurysm Of Thoracic Aorta.</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> (this hospital) attended the deceased from December 15, 1944 to May 13, 1961 that (we) last saw the deceased alive on May 13, 1961, and that death occurred at 12:35 PM from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>A.L. MOONEY</b> M.D.		<b>22b. DATE SIGNED</b> <b>5-14-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A.L. MOONEY, M.D., Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>5/15/61</b>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>WENDELINS CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>PITTSBURGH, PENNA.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>PENNINGTON &amp; SON, Havre DeGrace, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 18 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>			

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ORIGIN

POINT POINT

EXTENSIVE ALLEGATION OF CRIMINALITY

JOSEPH

PAULINE

ANDREW

JOHN

ATLANTA, GA.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5481

05472

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY in 1b <b>21</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		d. STREET ADDRESS <b>119 Stocton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Infant Dorothy Lynn Doles</b>		4. DATE OF DEATH <b>May 9, 1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1961</b>		9. AGE (In years last birthday) <b>3</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jay Willen</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Ellwood</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>776X</b>		17. INFORMANT <b>Jay Willen</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>776X</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>No</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Elkton</b>		20g. (County) <b>Cecil</b>		20h. (State) <b>Md.</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>5/7/61</b> to <b>5/9/61</b> , that (I) (we) last saw the deceased alive on <b>5/7/61</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>James L. Johnson</b>		22b. DATE SIGNED <b>5/12/61</b>		22c. PHYSICIAN'S NAME (Type) <b>James L. Johnson</b>		22d. ADDRESS <b>245 E. High St Elkton, Md</b>		22e. REC'D BY REGISTRAR <b>Ralph E. Nicks</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		22g. DATE <b>MAY 23 '61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park</b>		23d. LOCATION (City, town or county) <b>Elkton, Md.</b>		23e. (State) <b>Md.</b>		23f. (County) <b>Cecil</b>		23g. (City or town) <b>Elkton</b>		23h. (State) <b>Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



85000

STATE OF TEXAS

1881

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31

Presumptively

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Mr.

279 279 279

279 279

James E. Johnson  
James E. Johnson  
2423 14th St. Dallas, Tex.

James E. Johnson

1  
FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>Less than 24hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> d. STREET ADDRESS <b>418 S. Parke</b>			
3. NAME OF DECEASED (Type or print) <b>STEPHEN D. FRANKO</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 61</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-15-96</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Police Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Franko (deceased)</b>					
14. MOTHER'S MAIDEN NAME <b>Not available from records</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>WW-I 220-22-0744</b> 17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Pulmonary edema, both lungs.</b> DUE TO (b) <b>2. Arteriosclerotic heart disease.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. C. DODSON</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-16-61</b>			
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/19/61</b>		22b. DATE THEREOF <b>5/19/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>			
22d. LOCATION (City, town, or country) (State) <b>Havre de Grace, Md.</b>		23. FUNERAL DIRECTOR <b>Pennington &amp; Son, Havre de Grace, Md.</b>					
24a. REC'D BY REGISTRAR DATE <b>MAY 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

(M)

(I)

Good

Very faint

Veterans Administration Hospital

STATION

D.

FRANKO

NEW

IS

61

Male

White

x

9-15-36

61

Officer (Ret.)

Police Dept.

Greece

USA

James Franko (deceased)

Not available from records

SW-I

Yes

220-22-074

Hospital records, VA, very faint, etc.

2. Franko, James, born in Greece.

2. Franko, James, born in Greece.

x

x

x

x

9-15-36

Franko, James

H. C. DOWSON

Have to Greece, etc.

angel will

Franko, James, born in Greece, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5483

05474

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Cecil</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Liberty Grove</b> g. STREET ADDRESS <b>Rural</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ELI</b> Middle <b>Robert</b> Last <b>GRAYBEAL</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>15</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-5-95</b>
<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>66</b> Days <b>15</b> Hours <b>19</b> Min. <b>61</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James M. Graybeal (deceased)</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Anders (deceased)</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW-I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>036-07-6842</b>	
<b>17. INFORMANT</b> <b>Hospital Records, VAH, Perry Point, Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrothorax, bilateral (gastric contents &amp; blood)</b> DUE TO (b) <b>Rupture of esophagus, spontaneous, due to unknown cause</b> DUE TO (c) <b>unknown cause</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>36 hrs.</b> <b>36 hrs.</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>VA</b> e.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <del>XXXXXX</del> <b>XXXXXX</b> attended the deceased from <b>May 10</b> <b>1961</b> to <b>May 15</b> <b>1961</b> <del>XXXXXX</del> <del>XXXXXX</del> <b>XXXXXX</b> and that death occurred at <b>4:20pm</b> <del>XXXXXX</del> on the date stated above.		<b>22a. SIGNATURE</b> <b>A.L. Mooney</b> <b>A.L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>	
<b>22b. DATE SIGNED</b> <b>5-15-61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5-18-1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>West Nottingham</b>		<b>23d. LOCATION (City, town or county)</b> <b>West Nottingham, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Funeral Home, Rising Sun, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 18 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur P. K...</b>			

VR A15 (4)  
15M 9/60





1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5484

05475

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Newark R.D. Del.</b>			
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				d. STREET ADDRESS <b>1621 Nottingham Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b>		First		Middle <b>Thomas</b>		Last <b>Halliday</b>	
4. DATE OF DEATH <b>5-31-61</b>		Month		Day		Year	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-16-1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Antique Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Thomas Halliday</b>				14. MOTHER'S MAIDEN NAME <b>no information</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>221-22-9335</b>		17. INFORMANT <b>Mrs. George T. Halliday</b> Address <b>Newark, R.D. Del. 1621 Nottingham Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md. 6-1-61 DATE SIGNED							
ACTUAL SIGNATURE <b>R.C. Dodson</b>		EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/2/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery</b>		22d. LOCATION (City, town, or country) <b>Wilmington, Delaware</b>		22e. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
23. FUNERAL DIRECTOR <b>Ralph E. Hicks, Elkton, Md.</b>				24a. DATE <b>JUN 6 '61</b>			

MEDICAL CERTIFICATION

M

1

Local

Union

Union House Hotel

George

W

Antique Dealer

George Thomas Haliday

no

221-22-9335

Acute Coronary Occlusion

no information

Mrs. George T. Haliday 1621 Nottingham Rd.  
Newark, N.J.

Maryland

U.S.A.

10-16-1983

NY

Haliday

Thomas

2

31

61

1621 Nottingham Road

Newark N.J.

D.O.A.

Id.

Local

R.C. Dobson

Rising Sun, Md.

6-1-61

X

X

X

X

## CERTIFICATE OF DEATH

Reg. Dist. No. 05477

5485

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Husfelt</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May, 27 1961</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Husfelt</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gifford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Husfelt, Nottingham, Pa. R.D.#1.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Birth weight 1 lb 8 oz. Placenta previa</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> , 19 <b>61</b> , to <b>May 29</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>May 29</b> , 19 <b>61</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/31/61</b>			
ACTUAL SIGNATURE <b>Wallace Ohenschain</b>		M.D. <b>Cecilton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Ohenschain, M.D.</b>		Cecilton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 1, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Johnstown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Earleville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05478

5486

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Haven Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SOPHIA CORINNE JAMAR</b>		4. DATE OF DEATH <b>May 4 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>John H. Jamar</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hollingsworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. R. H. Blanchard, Evanston, Ill.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 12</b> , 19 <b>60</b> , to <b>May 4</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>61</b> , and that death occurred at <b>2:40</b> p. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>253 E. Main St. Elkton, Maryland</b> DATE SIGNED <b>5/5/61</b>			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b> M.D.		22a. REC'D BY REGISTRAR <b>MAY 9 '61</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr.</b>		22b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Donald H. Lee Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 9 '61</b>	

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M  
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VS A15 (4)  
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



02778

CERTIFICATE OF DEATH

1912

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint, illegible markings and a large handwritten signature in the lower right section.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
5487														
05479														
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Chester</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cecilton R.D.</b>					c. LENGTH OF STAY IN 1b <b>Visit.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Toughkenamon</b>									
					d. STREET ADDRESS <b>75 X-3</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year						
<b>George C. Jester</b>					<b>5 28 1961</b>									
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-20-1905</b>		9. AGE (In years last birthday) <b>55</b> yrs.						
								IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contract Carpenter</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>					11. BIRTHPLACE (State or foreign country) <b>Del.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>														
13. FATHER'S NAME <b>Frank Jester</b>					14. MOTHER'S MAIDEN NAME <b>Clara Bennett</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>183-07-3730</b>					17. INFORMANT <b>Danford Michael Jester Toughkenamon, R.D. Pa.</b>				
					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Drowned</b> <b>929-8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>Dived into river to save his son and did not come up.</b>														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dived into river and never came up.</b>									
20c. TIME OF INJURY Month, Day, Year <b>10:30 p.m. 5 28, 61</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>				
					20f. (City or town) <b>Cecilton Cecil Md.</b>					(County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <b>R.C. Dodson</b>					M.D. <b>Rising Sun, Md.</b>					DATE SIGNED <b>6-2-61</b>				
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF <b>June 5, 1961</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Union Hill</b>				
										22d. LOCATION (City, town, or country) (State) <b>Kenneth Square, Chester, Pa.</b>				
23. FUNERAL DIRECTOR <b>Edward Yellow Millington mrd.</b>					ADDRESS					24a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>				
										24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

THE STATE  
OF MARYLAND

(M)

(I)

Cecil

Cecil R.D.

Visit.

Toughman

Quarter

George

x

C.

laster

2

28

61

8-20-1902

22

Contract Carpenter

Carpenter

Del.

U.S.A.

Frank Lester

Glen Bennett

183-07-3730

Danford Michael Lester Toughman, R.D. No.

Drowned

Dived into river to save his son and did not come up.

x

Dived into river and never came up.

x

Jan 30

2 28 61

x

x River

Cecilton

Cecil

61

R.C. Johnson

Rising Sun, Md.

6-2-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be registered by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05480

5488

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	c. LENGTH OF STAY IN 1b <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>129 E. Main St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth A. Jones</b>		4. DATE OF DEATH Month Day Year <b>May 13, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>50</b> IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee Marvell</b>		14. MOTHER'S MAIDEN NAME <b>Cora Truitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Theodore S. Jones</b>		Address <b>Newark, Del.</b> <b>129 E. Main St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure (Acute Pulmonary edema)</b> <b>590X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Glomerulonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Valvulitis aortic and Corary arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 weeks</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March, 1959</b> to <b>5-13, 1961</b> , that I last saw the deceased alive on <b>5-13, 1961</b> , and that death occurred at <b>2-4</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>327 E Main Street Newark, Delaware</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Williford Eppes</b> M.D.		DATE SIGNED <b>May 18 '61</b>	
PHYSICIAN'S NAME (Type) <b>Williford Eppes</b>		DATE SIGNED <b>May 18 '61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 15, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Mem. Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Farnhurst, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. T. Jones</b>		ADDRESS <b>Newark Del.</b>	
24a. REC'D BY REGISTRAR <b>May 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Jones</b>	

• 1997 •

1995

VS. A15ME  
5M 7/59

## 05481

1. PLACE OF DEATH a. COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE		Connecticut b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		45x-3	
Elkton		DOA		Newton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Union Hospital		d. STREET ADDRESS		5 Schoolhouse Road	
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
John		R.		Lamberson		4. DATE OF DEATH	
						May 22, 19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-1-31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Construction foreman		Water tanks		Arkansas		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
William Lamberson		Ann Thrasher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		5 Schoolhouse Rd, Newton, Conn.	
		95-34-7192		Wife - Mrs. John R. Lamberson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Fracture skull, fracture rt humerus					
902.3		DUE TO		Crushed rt side chest,			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
		DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
		Landed on his head falling from a tank 120 feet in air					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
11:50 a.m. 5/22 19 61				Thiokol Co, Elkton, Md.		Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:							
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
R.C. Dodson		R.C. Dodson, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		May 22, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		5-26-61		Concoridia Cemetery		Hammond, Indiana	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
PIPPIN FUNERAL HOME		Donald M. De		May 24 '61		Arthur L. Thrasher	



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100-100000-100000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **05482**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Farms</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Farms-Newark, Del.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 E. Parkway Newark, Del.</b>		d. STREET ADDRESS <b>11 E. Parkway</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Ann</b> Last <b>Langley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Newburgh, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Catherine A. Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Glen Farms-Newark, Del.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Stenosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCVD</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14, 1961</b> to <b>April 30, 1961</b> , that I last saw the deceased alive on <b>April 30, 1961</b> , and that death occurred at <b>9:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Churchill E. Franklin</b>		ADDRESS (Street, city or town, state) <b>Hillside + Delton</b>	
PHYSICIAN'S NAME (Type) <b>Churchill E. Franklin M.D.</b>		DATE SIGNED <b>5-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 3, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bay View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jersey City, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. T. Jones</b>		ADDRESS <b>Newark, Del.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05483

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY CECIL  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Cecil                               |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point  |  |  |  | c. LENGTH OF STAY IN 1b 4yrs8mos9days  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton  |  |  |  |
|   |  |  |  | d. STREET ADDRESS 1 Route #2   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle (NMI) Last LONG   |  |  |  | 4. DATE OF DEATH Month May Day 6 Year 1961   |  |  |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH July 4, 1894                            |  |
| 9. AGE (In years last birthday) 66 yrs.   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Automobile   |  | 11. BIRTHPLACE (State or foreign country) North Carolina |  |
| 12. CITIZEN OF WHAT COUNTRY? USA  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME JONES LONG  |  |  |  | 14. MOTHER'S MAIDEN NAME NANCY KEY   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I  |  |  |  | 16. SOCIAL SECURITY NO. Unknown  |  |  |  |
| 17. INFORMANT Hospital Records, VAH., Perry Point, Md.  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage due to Hypertension<br>DUE TO (b) Arteriosclerosis, generalized and cerebral, moderately severe.<br>DUE TO (c) Unknown<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of 3rd, 4th, 6th ribs, left.  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH 30 Min. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                     |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE R. C. DODSON   |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) R. C. DODSON, M. D.  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  | 22b. DATE THEREOF 5/10/61  |  | 22c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETARY     |  |
| 22d. LOCATION (City, town, or country) BALTIMORE, MARYLAND  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR Pennington   |  |  |  | ADDRESS Harvch Bldg, Md  |  | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE       |  |
| DATE MAY 11 '61   |  |  |  | Arthur S. Kraus  |  |  |  |

MEDICAL CERTIFICATION

FOR OFFICE  
USE ONLY

(M)

(1)

20

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05484

5492

|  |   |   |  |  |   |  |  |
|--|---|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>5 yrs</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Devine Nursing Home</b>   |   |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>McCloskey</b> Last <b>McCloskey</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>24</b> , Year <b>1961</b>  |   |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 24, 1875</b>                    | 9. AGE (In years last birthday)<br><b>86</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. | IF UNDER 24 HRS.<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Delaware</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  | 13. FATHER'S NAME<br><b>John Barber</b>  |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Ellen Burge</b>   |   |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)                      |   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>Wm.B.McCloskey</b>   |   |   |  | 17. ADDRESS <b>Newark, Del.</b><br><b>160 W. Main Street</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>420.1</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b><br>(c) <b>Unknown</b> |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>Unknown</b>                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Elkton</b>                         | (County)<br><b>Cecil</b>   | (State)<br><b>Maryland</b>  |  |  |
| 21. I certify that I attended the deceased from <b>Sept 5</b> , 19 <b>60</b> , to <b>May 24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>May 4</b> , 19 <b>61</b> , and that death occurred at <b>9:30 P. M.</b> from the causes and on the date stated above.  |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Ralph Andrews Jr.</b>   |   | M.D. <b>233 E. Main St.</b>   |  | DATE SIGNED<br><b>5/24/61</b>  |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>J. RALPH ANDREWS, JR. M.D.</b>   |   | <b>ELKTON, MARYLAND</b>   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>May 27, 1961</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Head of Christiana Cem.</b>  | 22d. LOCATION (City, town, or county)<br><b>Newark, Del.</b> | (State)<br><b>Del.</b>   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.T. Jones</b>  |   | ADDRESS<br><b>Newark, Del.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAY 31 '61</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                    |  |  |



CERTIFICATE OF DEATH

Death

Register

Death

4

Age

Sex

Color

1901, 1902

1903, 1904

1905, 1906

1907, 1908

1909, 1910

1911, 1912

1913, 1914

1915, 1916

W. A. Colver, Jr., Main Street, Newark, N. J.

1917, 1918

1  
FOR STATE  
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
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| 05485   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b> <b>MARYLAND</b>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>                 |  |  |  |  |   |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cecilton, Rural</b>   |  |  |  |  | c. LENGTH OF STAY IN 1b <b>30 years</b>   |  |  |  |  |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |  |  |  | d. STREET ADDRESS <b>Warton R.F.D.</b>  |  |  |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Lewis Wilson Morris</b>  |  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>5 26 19 61</b>   |  |  |  |  |   |  |  |  |  |
| 5. SEX <b>M</b>   |  | 6. COLOR OR RACE <b>W</b>                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>6-18-1930</b>          |  | 9. AGE (In years last birthday) <b>30 yrs.</b>   |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |
| 13. FATHER'S NAME <b>Clarence H. Morris</b>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Addie Biddle</b>  |  |  |  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>   |  |  |  |  | 16. SOCIAL SECURITY NO. <b>220-28-2167</b>  |  |  |  |  | 17. INFORMANT <b>Clarence H. Morris, Cecilton, Md.</b> Address      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture of Base of skull and abrasions and contusions over body laceration of ears.</b><br>822X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(b) <b>contusions over body laceration of ears.</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Car turned over and threw him out, under it.</b> |  |  |  |  | 20c. TIME OF INJURY Month, Day, Year<br><b>6:55 a.m. 5 28 19 61</b> |  |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>route 286</b>   |  |  |  |  | 20f. (City or town) <b>Cecilton Cecil Md.</b> (County) (State)      |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| ACTUAL SIGNATURE <b>R.C. Dodson</b>   |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  | DATE SIGNED <b>5-28-61</b>  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>R.C. Dodson</b>   |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Rising Sun, Md.</b>  |  |  |  |  |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |  |  |  | 22b. DATE THEREOF <b>JUNE 1</b>   |  |  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>CHURCH HILL</b>               |  |  |  |  |
| 22d. LOCATION (City, town, or country) <b>CHURCH HILL MD.</b>   |  |  |  |  | 22e. (State)  |  |  |  |  |   |  |  |  |  |
| 23. FUNERAL DIRECTOR <b>Edgar L. Kane</b>   |  |  |  |  | ADDRESS <b>Church Hill, Ind.</b>  |  |  |  |  | 24a. REC'D BY REGISTRAR <b>JUN 5 '61</b>                            |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |



2503

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

Geoff

Ma.

Geoff

Geoff, Rural

30 years

Winton R. D.

Lewis

Wilson

Morris

2

28

61

W

M

6-18-1930

30

Farm laborer

Farming

Ma.

U.S.A.

Clarence H. Morris

Abbie Biddle

230-28-2167

Clarence H. Morris, Geoff, Ma.

Fracture of base of skull and abrasions and contusions over body

contusions over body laceration of ears.

x

Car turned over and threw him out, under it.

6.25

2 28 61

x route 286

Geoff

Geoff

Ma.

R.C. Johnson

Rising Sun, Ma.

2-26-61

Handwritten notes at the bottom of the page, including "June 1 Church Hill" and "Clarence H. Morris".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5494

05486

|   |   |  |  |
|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Cecil</b> <b>MARYLAND</b>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <b>England</b> b. COUNTY  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Point</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lancashire</b>  |  |
| c. LENGTH OF STAY in b<br><b>35yrs.10mo.21days</b>  |   | d. STREET ADDRESS<br><b>4 Edmund Street, Darwen</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br><b>GEORGE S. NANSEN</b>   |   | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>May 21 19 61</b>   |  |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>9-1-87</b> |
| <b>9. AGE</b> (In years last birthday)<br><b>73 yrs.</b>  |   | <b>IF UNDER 1 YEAR</b><br>Months Days  | <b>IF UNDER 24 HRS.</b><br>Hours Min.    |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Sailor</b>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Merchant Marines</b>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>England</b>  |   | <b>12. CITIZEN OF WHAT COUNTRY</b><br><b>USA</b>   |  |
| <b>13. FATHER'S NAME</b><br><b>Not available from records.</b>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Not available from records.</b>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>Yes WW I</b>   |   | <b>16. SOCIAL SECURITY NO.</b><br><b>Not available</b>   |  |
| <b>17. INFORMANT</b> Address<br><b>Hospital Records, VAH, Perry Point, Md.</b>  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Encephalomalacia due to circulatory disturbance (embolism)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Infarction of myocardium with mural thrombus due to arteriosclerotic coronary thrombosis</b><br>(c) <b>Arteriosclerotic heart disease</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>unknown</b><br><b>unknown</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>VA 19</b>  |   | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify</b> that <del>XXXXXX</del> attended the deceased from <b>June 30, 1961</b> to <b>May 21, 1961</b> and that death occurred at <b>7:00am</b> from the causes and on the date stated above.   |   |  |  |
| <b>22a. SIGNATURE</b><br><b>A.L. Mooney</b>   |   | <b>22b. DATE SIGNED</b><br><b>5-25-61</b>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>A.L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>   |   | <b>22d. ADDRESS</b>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>5/31/61</b>  |   | <b>23b. DATE THEREOF</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Baltimore National</b>  |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Baltimore, Maryland</b>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Pennington &amp; Son, Havre de Grace, Md.</b>   |   | <b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 5 '61</b>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Huns</b>  |   |  |  |

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(M)

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Party Join

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Administration Hospital

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White

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Salor

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VS. A15ME  
5M 7/59



u5487

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>e. COUNTY<br><b>cecil</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE<br><b>Wis.</b>  |  | b. COUNTY<br><b>DUNN Co.</b>  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Earlville</b>   |  | c. LENGTH OF STAY IN lb<br><b>few days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Menomonie</b>  |  | d. STREET ADDRESS<br><b>86X-3</b>                                     |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Peter</b>   |  | First<br><b>O</b>   |  | Middle<br><b>Peterson</b>   |  | Last  |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-13-1880</b>                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Menomonie, Wis.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |  |
| 13. FATHER'S NAME<br><b>Adolph Peterson</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Christopher</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. Peter O. Peterson, Menomonie, Wis.</b>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO<br>(b)<br>(c)   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)               |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br><b>5-20-61</b>   |  |
| ACTUAL SIGNATURE<br><b>R.C. Dodson</b>   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br><b>Rising Sun, Md.</b>                                |  |   |  |   |  |
| EXAMINER'S NAME (Type)<br><b>R.C. Dodson</b>   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>5/27/61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Little Elk Lake Cemetery</b> |  |
| 23. FUNERAL DIRECTOR<br><b>Edward J. Kowalski</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Menomonie, Wis.</b>                                  |  | 24a. REC'D BY REGISTRAR<br><b>May 24 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. K...</b>                  |  |



M

Barville

few days

Memoranda

W.A.

Geoff

Peter

O

Peterson

X

2-13-1980

61

Refined Farmer

Training

Memoranda, W.A.

U.S.A.

Adolph Peterson

Julia Christopher

on

Mrs. Peter O. Peterson, Memoranda, W.A.

Acute Coronary Occlusion

X

X

X

X

R. J. Dobson

Rising Sun, Md.

2-20-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5496

05488

Item 7 Film G286 5/26/61

|  |                            |  |                                   |  |  |
|--|----------------------------|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CECIL</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN RURAL</b><br>c. LENGTH OF STAY IN 1b <b>Life</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD.</b><br>b. COUNTY <b>CECIL</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN RURAL</b><br>d. STREET ADDRESS <b>1</b> |                                   | e. IS RESIDENCE ON A FARM? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PHILIP</b> Middle <b>HENRY</b> Last <b>RILEY</b>   |                            | 4. DATE OF DEATH<br>Month <b>5/</b> Day <b>17</b> Year <b>1961</b>   |                                   |  |  |
| 5. SEX <b>M.</b>   | 6. COLOR OR RACE <b>W.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>5/24/1901</b> | 9. AGE (In years last birthday) <b>59</b> yrs.   | IF UNDER 1 YEAR: Months <b>5</b> Days <b>17</b> Hours <b>19</b> Min. <b>61</b>                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER</b>   |                            | 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>  |                                   | 11. BIRTHPLACE (State or foreign country) <b>PA.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                            |  |                                   |  |  |
| 13. FATHER'S NAME <b>HENRY RILEY</b>   |                            | 14. MOTHER'S MAIDEN NAME <b>ANNA MYERS</b>   |                                   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |                            | 16. SOCIAL SECURITY NO. <b>216-07*5769</b>   |                                   | 17. INFORMANT <b>MRS. PHILIP RILEY</b> Address <b>RISING SUN, MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>150X</b> <b>Cerebral Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse Hypocephalic Cerebral Hemorrhage</b><br>(c) <b>Diffuse Hypocephalic Cerebral Hemorrhage</b> |                            |  |                                   |  | INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                            |  |                                   |  | 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                            | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                            | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                       |  |
| 20f. (City or town) (County) (State)   |                            |  |                                   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1961</b> to <b>May 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1961</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.  |                            |  |                                   |  |  |
| 22a. SIGNATURE <b>Dr. T. H. Halcum, M.D.</b>   |                            | 22b. DATE <b>May 18, 61</b>  |                                   | 22c. PHYSICIAN'S NAME (Type or print) <b>Dr. T. H. Halcum, M.D.</b>  |  |
| 22d. ADDRESS <b>1</b>  |                            | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                            | 23b. DATE THEREOF <b>5/21/1961</b>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY <b>BROOKVEIW CEM.</b>   |  |
| 23d. LOCATION (City, town, or county) <b>RISING SUN MD.</b>  |                            |  |                                   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Norman E. McMiller</b>   |                            | 24a. ADDRESS <b>RISING SUN, MD.</b>  |                                   | 25a. REC'D BY REGISTRAR <b>MAY 22 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Samuel L. Thomas</b>   |                            |  |                                   |  |  |

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *Jan 15 1920*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *Dr. J. H. Smith*  
8. Signature of registrar: *John Doe*  
9. Date of registration: *Jan 15 1920*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                           |   |   |   |  |  |  |   |  |
|--|--|---------------------------|---|---|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |   |   |   |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                           |   |   |   |  |  |  |   |  |
| 5497   |  |                           |   |   |   |  |  |  |   |  |
| 05484  |  |                           |   |   |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b>  |  |                           |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East, R.D.</b>   |  |                           |   |   | c. LENGTH OF STAY IN 1b <b>15 yrs.</b>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  |                           |   |   | d. STREET ADDRESS <b>North East R.D.</b>  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>George William Rinkerman</b>  |  |                           |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>5 17 19 61</b>   |  |  |  |   |  |
| 5. SEX <b>M</b>  |  | 6. COLOR OR RACE <b>W</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>8-23-1896</b> Aug 23 1896 |  | 9. AGE (in years last birthday) <b>64</b> yrs.                 |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Guard at Fiber Plant Guard</b>   |  |                           |   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b> |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |                           |   |   |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>Lewis Rinkerman</b>  |  |                           |   |   | 14. MOTHER'S MARRIAGE NAME<br><b>No information</b>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                           |   |   | 16. SOCIAL SECURITY NO. <b>220-03-0725</b>  |  |  |  |   |  |
| 17. INFORMANT<br><b>Mrs. George W. Rinkerman, North East, Md.</b>  |  |                           |   |   | Address   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                           |   |   |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>  |  |                           |   |   |   |  |  |  |   |  |
| 420.0 DUE TO   |  |                           |   |   |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (b) <b>5 minutes</b>  |  |                           |   |   |   |  |  |  |   |  |
| (e), stating the underlying cause last. (c) <b>Arteriosclerotic Heart Disease.</b>   |  |                           |   |   |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                           |   |   |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                           |   |   |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                           |   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                         |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                           |   |   |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>R.C. Dodson</b>  |  |                           |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |   |  |
| EXAMINER'S NAME (Type) <b>R.C. Dodson</b>  |  |                           |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |                           |   |   | DATE SIGNED <b>5-17-61</b>  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                           |   |   | 22b. DATE THEREOF <b>May 20, 1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Head of Christiana</b> |  | 22d. LOCATION (City, town, or country) (State)<br><b>Newark, Delaware</b> |  |
| 23. FUNERAL DIRECTOR<br><b>R.T. Jones</b>  |  |                           |   |   | ADDRESS<br><b>Newark, Del.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>MAY 24 '61</b>                 |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hume</b>                      |  |

THE STATE  
DEPARTMENT

(M)

(1)

Geoff

North East, R.D.

15 yrs.

North East R.D.

Mo.

Geoff

George

William

Rinkerman

17

2

01

8-23-1925

x

Guard at River Plant Guard

New Jersey

U.S.A.

James Rinkerman

No information

220-03-0725

Mrs. George W. Rinkerman, North East, Mo.

Acute Coronary Occlusion

2 minutes

Arteriosclerotic Heart Disease.

x

R.C. Dodson

Hislop Sun, Mo.

2-17-01

x

x

x

x

x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5498

CERTIFICATE OF DEATH

Reg. Dist. No.

05490

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u> Cecil </u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u> Md </u> b. COUNTY <u> Cecil </u>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>  |  |   |  | c. LENGTH OF STAY IN 1b <u> 21 </u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u> Union </u>   |  |   |  | d. STREET ADDRESS <u> Elkton </u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>GLENN First ROBERT Middle Last <u> JR. </u>  |  |   |  | 4. DATE OF DEATH<br>Month <u> May </u> Day <u> 11 </u> Year <u> 1961 </u>  |  |   |  |
| 5. SEX<br><u> Male </u>   |  | 6. COLOR OR RACE<br><u> White </u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u> May 11, 1961 </u>   |  |
| 9. AGE (In years last birthday)<br><u> 15 </u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |  | IF UNDER 24 HRS.<br>Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u> None </u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u> None </u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u> Elkton, Maryland </u>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u> 6 </u>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><u> Glenn R. Rose Sr. </u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u> Virginia Myers </u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> No </u> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><u> None </u>   |  |   |  |
| INFORMANT<br><u> Glenn R. Rose Sr. </u>   |  |   |  | Address<br><u> Elkton, Md. </u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u> Acute anoxia </u><br>759.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> Multiple congenital abnormalities </u><br>DUE TO (c) <u> </u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u> 15 min </u><br><u> ? </u> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u> 19 </u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <u> 5/4 </u> , 19 <u> 61 </u> , to <u> 5/11 </u> , 19 <u> 61 </u> , that I last saw the deceased alive on <u> 5/11 </u> , 19 <u> 61 </u> , and that death occurred at <u> 5:50 P.M. </u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u> Elkton, Md. </u> DATE SIGNED <u> 5/13/61 </u>                                 |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u> Peter Stavrakis </u> M.D.  |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u> PETER STAVRAKIS, M.D. </u>  |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u> Burial </u>  |  | 22b. DATE THEREOF<br><u> 5/18/61 </u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u> Tazewell Cemetery </u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u> Tazewell, Virginia </u>                      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u> W. H. PIPPIN FUNERAL HOME </u>  |  |   |  | ADDRESS<br><u> Elkton, Md. </u>  |  | 24a. REC'D BY REGISTRAR<br><u> MAY 17 '61 </u>  |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u> Arthur L. King </u>  |  |   |  |

2065253XV3



CERTIFICATE OF DEATH

1907

(4)

100-100

*[Faint, mostly illegible text and markings on a form, likely a death certificate. The text is mirrored and appears to be bleed-through from the reverse side of the page. Some legible fragments include:]*

*NAME OF DECEASED*  
*DATE OF DEATH*  
*PLACE OF DEATH*  
*Cause of Death*  
*Signature of Physician*  
*Signature of Registrar*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G288 6/16/61 mh

## CERTIFICATE OF DEATH

Reg. Dist. No.

5495

05491

|   |                                  |  |  |  |   |   |  |
|---|----------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural North East</b>   |                                  |  |  | c. LENGTH OF STAY IN 1b<br><b>22 years</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |  |  | d. STREET ADDRESS  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ethel</b> Middle <b>B.</b> Last <b>Schjerup</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>30th</b> Year <b>19 61</b>   |   |   |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 13th, 1906</b> | 9. AGE (In years last birthday)<br><b>55 54 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School Teacher</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Junior High</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Rasmus B. Schjerup</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Jackson</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>185-20-4470</b>  |  | INFORMANT Address<br><b>Mrs Edward Winner North East, Maryland</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of left breast with metastasis</b><br>170X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) —<br>(c) —<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs, 7 mo.</b> |                                  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>— 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>21 April, 1961</b> , to <b>30 May, 1961</b> , that I last saw the deceased alive on <b>29 May, 1961</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>North East, Md</b> DATE SIGNED <b>5/30/61</b><br>ACTUAL SIGNATURE <b>Klaus H. Huebner</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner M.D.</b>  |                                  |  |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>June 6, 1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>North East Methodist</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>North East, Cecil Co., Md</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Grant</b><br>ADDRESS<br><b>North East, Maryland</b>  |                                  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUN 5 '61</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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COUNTY OF DALLAS

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FOR STATE  
HEALTH DEPT.

TO DEEDY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 20d, Film G-286 5/11/61.cac.

05492

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Earlville</b><br>c. LENGTH OF STAY IN 1b<br><b>DOA</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Harford</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Havre De Grace</b><br>d. STREET ADDRESS<br><b>228 Wilson</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>James Taylor Strowgune</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>5-2-</b> Day <b>1961</b>   |  |  |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>11-10-39</b>  |  |
| 9. AGE (In years last birthday)<br><b>21</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>24</b> Hours <b>2</b> Min.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>operator</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Huber Chemical Co.</b>               |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Havre De Grace, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Andrew Strowgune</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Maurice</b>                          |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Peace time</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Phillis D. Strowgune, 228 Wilson St.,</b>   |  | Address<br><b>Havre De Grace, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Exposure &amp; drowning</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Drowning in Susquehanna River</b> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Boat upset</b>     |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>7:30 a.m. 5-2- 1961</b>   |  | 20d. INJURY OCCURRED<br><input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Susquehanna River</b>  |  | 20f. (City or town) (County) (State)<br><b>Havre De Grace, Harford, Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                            |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>R. C. Dodson MD</b>  |  |  |  | M.D.<br><b>R. C. Dodson MD</b>  |  | DATE SIGNED<br><b>5-4-61</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF<br><b>5/6/61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Concord Hill</b>   |  | 22d. LOCATION (City, town, or country) (State)<br><b>Havre De Grace, Md.</b> |  |
| 23. FUNERAL DIRECTOR<br><b>William H. Dodson</b>  |  |  |  | ADDRESS<br><b>1001 N. Harbor Lane, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>May 8 '61</b>                                  |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>   |  |  |  |

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Have De Grace

1001 Wilson

James Taylor Brown

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11-10-30

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Imperial Chemical Co.

Have De Grace, N. J.

operating

Andrew Spence

Have De Grace, N. J.

Have De Grace, N. J.

Have De Grace, N. J.

Exposure to gas

Exposure to gas

X

Have De Grace, N. J.

X

Have De Grace, N. J.

X

X

X

Have De Grace, N. J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 5501 Item 23b, Film G287 5/25/61 iwk 05493   |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b> <b>MARYLAND</b>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>             |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perryville,</b>   |  |  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>86 Days</b>  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>V.A.H. Perry Point,</b>   |  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arlington</b>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>RICHARD A. THAYER</b>  |  |  |  |  |  | d. STREET ADDRESS<br><b>2809 -13th Road, South</b>   |  |  |  |  |  |
| 5. SEX <b>Male</b>   |  |  |  |  |  | 4. DATE OF DEATH<br><b>May 4 19 61</b>   |  |  |  |  |  |
| 6. COLOR OR RACE <b>White</b>  |  |  |  |  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |
| 8. DATE OF BIRTH<br><b>9-22-14</b>   |  |  |  |  |  | 9. AGE (In years last birthday)<br><b>46 yrs.</b>  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Florist</b>  |  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Florist</b>  |  |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Augusta, maine</b>   |  |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Roy B. Thayer</b>  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Marion Appleton</b>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>  |  |  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>005-09-9116</b>  |  |  |  |  |  |
| 17. INFORMANT<br><b>Hospital Records - VAH.</b>  |  |  |  |  |  | Address  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis due to extravasated contents of</b><br><b>Visera</b><br>DUE TO (b) <b>Irradiation effects for treatment of</b><br><b>Undifferentiated Malignancy.</b><br>DUE TO (c) <b>(Abdominal Nymph node)</b> |  |  |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of Seminoma</b>   |  |  |  |  |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Wks</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 7, 1961, to May 4, 1961</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>A.L. Mooney</b> M.D.  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. DATE SIGNED<br><b>5/5/61</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr A.L. MOONEY, Pathologist</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 22d. ADDRESS<br><b>VAH., Perry Point, Md.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 23b. DATE THEREOF<br><b>5/9/61</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Hope Cemetary</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION (City, town or county) (State)<br><b>Augusta, Maine</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bennington &amp; Son, Haverde Grace, Md</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR<br><b>MAY 19 1961</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thayer</b>  |  |  |  |  |  |  |  |  |  |  |  |





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CONFIDENTIAL

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• Official Records -

Q. P. Moore

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• *Very Toxic* •

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>✓</b></span> |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Perry Point</b>  |  | c. LENGTH OF STAY IN 1b<br><b>35yrs. 10mo. 21days</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |  | d. STREET ADDRESS<br><b>332 South Smallwood</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Veterans Administration Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>ANDREW</b> Middle <b>(NMI)</b> Last <b>THOMPSON</b>  |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>May</b> Day <b>17</b> Year <b>1961</b>   |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>2-2-92</b>   |  |
| 9. AGE (In years last birthday)<br><b>69</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>69</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Not available from records</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Not available from records</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO.<br><b>WW I</b>   |  | 17. INFORMANT<br><b>Hospital Records, VAH, Perry Point, Md.</b>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic coma</b><br>587.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Obstruction of common bile duct, severe</b><br>DUE TO<br>(c) <b>Chronic pancreatitis</b> |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus</b>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Interval between ONSET AND DEATH</b><br><b>36 hrs.</b> |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>VA</b> 19<br>p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>6-8 weeks</b>   |  | 20f. (City or town) (County) (State)<br><b>unknown</b>  |  |
| 21. I certify that (b) (this hospital) attended the deceased from <b>June 17</b> to <b>May 18</b> , 19 <b>61</b> , and that death occurred <b>10:45pm</b> from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>A.L. Mooney</b>  |  |   |  | 22b. DATE SIGNED<br><b>5-18-61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>A.L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |  | 23b. DATE THEREOF<br><b>5/23/1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b>                                       |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. Kneass</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAY 25 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles L. Kneass</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

502

Cell

Army, John

Army, John, Sidney

Army, John

Veterans Administration Hospital

302 South Main Street

(M)

THOMAS

17

17

Male

White

2-2-32

29

Former

Farmer

Farmer

USA

Not available from records

Not available from records

Yes

Not available from records

Not available from records, V.A. Army, John, M.

Hepatic coma

30 M.

Distention of common bile duct, severe

6-8 weeks

Gastrointestinal

undigested

Diabetes mellitus

X

V

17

25

18

17-18-19

RECORDS SECTION, VETERANS ADMINISTRATION

10:30 PM

W. H. Hootch

A.A. Hootch, Jr., Medical Pathologist, V.A. Hospital, M.

Baltimore, Md.

Baltimore National

RECORDS SECTION, VETERANS ADMINISTRATION

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It is to be used with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

5503

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05495

|   |                        |   |  |  |  |
|---|------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Cecil MARYLAND   |                        |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE North Carolina b. COUNTY ✓ |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point  |                        |   | c. LENGTH OF STAY IN 1b 33yrs. 4mo. 1day   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital   |                        |   | d. STREET ADDRESS 1820 Wolcott Avenue 70X-3  |  |  |
| 3. NAME OF DECEASED (Type or print) ISAAC G. TILLERY  |                        |   | 4. DATE OF DEATH Month May Day 28 Year 1961  |  |  |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH 7-9-93  |  | 9. AGE (In years last birthday) 67 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk   |                        | 10b. KIND OF BUSINESS OR INDUSTRY A.C.L. Railroad   |  | 11. BIRTHPLACE (State or foreign country) Virginia                     |  |
| 12. CITIZEN OF WHAT COUNTRY? USA  |                        | 13. FATHER'S NAME Leon B. Tillery   |  | 14. MOTHER'S MAIDEN NAME Magdalene Lynch                               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-I  |                        | 16. SOCIAL SECURITY NO. Not available   |  | 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, severe.<br>4-20-66 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe.<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                        |   |  |  | INTERVAL BETWEEN ONSET AND DEATH 15 min. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |                        | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE R. C. DODSON   |                        | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED 5/29/61  |  |
| EXAMINER'S NAME (Type) R. C. DODSON   |                        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Address (Street, city, town, or county) Rising Sun, Md.                |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  |                        | 22b. DATE THEREOF 6/1/1961  |  | 22c. NAME OF CEMETERY OR CREMATORY Arlington National                  |  |
| 22d. LOCATION (City, town, or country) Arlington, Va.   |                        | 23. FUNERAL DIRECTOR'S NAME (Type) Joseph Gawler's Sons, 1756 Penna. Ave., N.W. Wash. D.C.  |  |  |  |
| 24a. REC'D BY REGISTRAR DATE MAY 31 '61   |                        | 24b. REGISTRAR'S SIGNATURE  |  |  |  |

M

1

WILLIAM

William Harrison

WILLIAM HARRISON



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05496

|   |                              |  |                                      |
|---|------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b><br>c. LENGTH OF STAY IN 1b<br><b>4 hours</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Union Hospital</b>   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Cecil</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b><br>d. STREET ADDRESS<br><b>292 Hollings Manor</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Norman Ellis Tweed, Jr.</b>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><b>5 30 61</b>   |                                      |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>4-12-1937</b> |
| 9. AGE (in years last birthday)<br><b>24 yrs.</b>   |                              | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Equip. Oper.</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Const.</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Norman Ellis Tweed, Sr.</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Blanche Mc Dowell</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>no</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>215-34-1327</b>  |                                      |
| 17. INFORMANT<br><b>Norman Ellis Tweed, Sr. Elkton, Md.</b>   |                              | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture base of skull left femur abrasions both arms face back Lacerated scalp multiple bruises over body.</b><br>DUE TO (b) <b>815 X</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO (c) <b>over body.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Was dragged under car.</b> |                              |  |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Was thrown from motor bike in front of car.</b>  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>5-30-61</b><br>a.m. <b>5-30-61</b><br>p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Route 7</b>  |                              | 20f. (City or town) (County) (State)<br><b>Elkton Cecil Md.</b>  |                                      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                              |  |                                      |
| ACTUAL SIGNATURE<br><b>R.C. Dodson</b><br>EXAMINER'S NAME (Type)<br><b>R.C. Dodson M.D.</b>   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br><b>Rising Sun, Md.</b><br>DATE SIGNED<br><b>5-31-61</b>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>5/2/1961</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Gilpin Manor Memorial Park</b>   |                              | 22d. LOCATION (City, town, or country) (State)<br><b>Nr. Elkton, Maryland</b>  |                                      |
| 23. FUNERAL DIRECTOR<br><b>PIPPIN FUNERAL HOME</b>  |                              | 24a. REC'D BY REGISTRAR<br><b>DATE JUN 5 '61</b>   |                                      |
| ADDRESS<br><b>Elkton, Md.</b>   |                              | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                      |





Cecil

Md.

Cecil

Union Hospital

4 hours

Union

202 Hollings Manor

Union Hospital

of

30

2

Hills Tweed, Jr.

Norman

4-12-1937

U.S.A.

Blanche Mc Dowell

Norman Hills Tweed, Jr.

Norman Hills Tweed, Jr. Union, Md.

215-34-1937

no

Fracture base of skull left femur abrasions both

arms face back lacerated scalp multiple bruises

over body.

Was dragged under car.

Was thrown from motor bike in front of car.

4-30-61

Route 7

Union

Cecil

Md.

2-31-61

Blanche Mc Dowell

R.C. Dobson M.D.

5505

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05497

|   |                               |  |                                      |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cecil</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>                 |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Rural</b>   |                               | c. LENGTH OF STAY IN 1b <b>Life</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Manor Heights</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nora</b> Middle <b>Whitaker</b> Last <b>Whitaker</b>  |                               | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>15</b> Year <b>19 61</b>   |                                      |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. 7, 1866</b> |
| 9. AGE (In years lost birthday) <b>94</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |                                      |
| 13. FATHER'S NAME <b>Samuel Whitaker</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Margaret Whitelock</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT <b>Ollie Whitaker, Port Deposit, Md.</b>  |                               | Address <b>R FD</b>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b><br><b>334X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerosis -</b><br>DUE TO (c) |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>8 yrs.</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                      |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 17 1961</b> to <b>May 14 1961</b> , that (I) (we) last saw the deceased alive on <b>May 14 1961</b> , and that death occurred at <b>7:50</b> M, from the cause and on the date stated above.   |                               |  |                                      |
| 22a. SIGNATURE <b>Clarence I. Benson</b> M.D.   |                               | 22b. DATE SIGNED <b>May 16 1961</b>  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <b>Clarence I. Benson</b>  |                               | 22d. ADDRESS <b>Port Deposit, Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>5-18-1961</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>   |                               | 23d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md., Rural</b>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Lea A. Patterson &amp; Son,</b>   |                               | ADDRESS <b>Perryville, Md.</b>   |                                      |
| 25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>   |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>   |                                      |

WILLIAM D. MONTAGNA, JR., M.D., F.A.C.P., F.A.C.C.

1  
FOR STATE  
HEALTH DEPT.

If any day is necessary, this certificate should be executed within 24 hours after death and forwarded to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(X)

(I)

MEDICAL CERTIFICATION

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5506

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05498

|   |                           |   |  |  |                                |   |  |  |
|---|---------------------------|---|--|--|--------------------------------|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Cecil MARYLAND  |                           |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Cecil<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Chesapeake City<br>d. STREET ADDRESS<br>Chesapeake City |  |                                | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>DANIEL YONKO   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>May 22, 1961   |  |                                |   |  |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Jan. 14, 1876  | 9. AGE (in years last birthday)<br>85 yrs.                             | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>U S Govt.  |  | 11. BIRTHPLACE (State or foreign country)<br>Austria                   |                                | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |
| 13. FATHER'S NAME<br>No Info.   |                           |   | 14. MOTHER'S MAIDEN NAME<br>No Info.   |  |                                |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>Pauline Yonko Chesapeake City, Md.<br>Address         |                                |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-nephritic<br>442X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerosis<br>(a), stating the underlying cause last. DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |   |  |  |                                |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 Yrs.<br>20 Yrs |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |                                |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                                | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                           |   |  |  |                                |   |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>R. C. Dodson M. D.  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                    |                                | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |  |  |
|   |                           | DATE SIGNED<br>May 22, 1961   |  | Rising Sun, Md.  |                                |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>5-24-61  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>St. Roses Cemetery               |                                | 22d. LOCATION (City, town, or country) (State)<br>Chesapeake City, Md.                            |  |  |
| 23. FUNERAL DIRECTOR<br>ADDRESS<br>HIPPIN FUNERAL HOME Donald H. Ree  |                           |   |  | 24a. REC'D BY REGISTRAR<br>Elkton, Md.<br>DATE MAY 24 '61              |                                | 24b. REGISTRAR'S SIGNATURE<br>Charles P. Kline  |  |  |





1  
FOR STATE  
HEALTH DEPT.

May be necessary, if any, to file this certificate with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07865

|   |                       |   |                                |   |                                       |  |  |
|---|-----------------------|---|--------------------------------|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Cecil  |                       |   |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Md. b. COUNTY Cecil |                                       |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Elkton  |                       |   |                                | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Elkton, R.F.D.1                   |                                       |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Union Hospital  |                       |   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                                       |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Adolph   |                       | Middle Yukenvith  |                                | Last  |                                       | 4. DATE OF DEATH<br>Month 5 Day 29 Year 19 61                      |  |
| 5. SEX<br>M   | 6. COLOR OR RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12-11-1894 |   | 9. AGE (in years last birthday)<br>68 | IF UNDER 1 YEAR<br>Months Days                                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Handy man  |                       | 10b. KIND OF BUSINESS OR INDUSTRY<br>Chicken Farm   |                                | 11. BIRTHPLACE (State or foreign country)<br>Lithawina  |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                             |  |
| 13. FATHER'S NAME<br>Stanley Yukenvith  |                       |   |                                | 14. MOTHER'S MAIDEN NAME<br>Stephnia Gessavich  |                                       |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                       | 16. SOCIAL SECURITY NO. (If yes give war or date of service)  |                                | 17. INFORMANT<br>John Martinuk, Elkton, R.D.1 Md.   |                                       |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Coronary Occlusion<br>420.1 DUE TO Arterio sclerosis<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)   |                       |   |                                |   |                                       | INTERVAL BETWEEN ONSET AND DEATH<br>15 min.                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                       |   |                                |   |                                       |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                |   |                                       |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. 19  |                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Rising sun, Md. DATE SIGNED 5-30-61 |                       |   |                                |   |                                       |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>R.C. Dodson   |                       |   |                                |   |                                       |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                       | 22b. DATE THEREOF<br>6/4/61   |                                | 22c. NAME OF CEMETERY OR CREMATORY<br>Cherry Hill Cemetery  |                                       | 22d. LOCATION (City, town, or country) (State)<br>Cherry Hill, Md. |  |
| 23. FUNERAL DIRECTOR<br>ADDRESS<br>Ralph E. Hicks, Elkton, Md.  |                       |   |                                | 24a. REC'D BY REGISTRAR<br>DATE JUN 10 '61  |                                       | 24b. REGISTRAR'S SIGNATURE<br>C. L. S. Kraus                       |  |

MEDICAL CERTIFICATION



THE STATE  
DEPARTMENT

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Elison, A. J.

B. C. A.

12-11-10

Elison, A. J.

Elison, A. J.

Elison, A. J.

Elison, A. J.

Elison, A. J.

10-11-10

Elison, A. J.

Elison, A. J.

Elison, A. J.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

M

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| Item 7 Film 0288 6/12/61 mh   |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  | Cecil  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE |  |  |  | Penna.  |  | b. COUNTY   |  | Del. Co.  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |  | Rural Elkton   |  | c. LENGTH OF STAY IN lb   |  | 2½ Hrs  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |  | Media   |  | 75X-3   |  | d. STREET ADDRESS   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |  |  |   |  |   |  | 4 General Washington Drive   |  | e. IS RESIDENCE ON A FARM?                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First  |  | Middle  |  | Last  |  | 4. DATE OF DEATH   |  | Month   |  | Day   |  | Year  |  |
| JAMES   |  | PAUL   |  | ZEARLEY   |  |   |  | May 31,  |  |   |  |   |  | 1961  |  |
| 5. SEX  |  | 6. COLOR OR RACE   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  |   |  |
| Male  |  | White  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 3/8/1907  |  | 54 yrs.  |  | Months  |  | Days  |  | Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |   |  |   |  |   |  |
| Photo.  |  | Equipment  |  | Penna.  |  | USA   |  |  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME   |  | Edmond L. Zearley  |  | 14. MOTHER'S MAIDEN NAME  |  | Effie Colebank  |  |  |  |   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | Address   |  |  |  |   |  |   |  |   |  |
| No  |  | 716-12-4008  |  | Helen M. Zearley  |  | Media, Penna.   |  |  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | Mangled Body  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |   |  |   |  |
| 802X  |  | DUE TO   |  | Hit by Train(Railroad)  |  |   |  |  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |  | (c)   |  |   |  |  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  |   |  |  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  | Hit by Train while taking pictures  |  |   |  |  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  | 20f. (City or town)   |  | (County)   |  | (State)   |  |   |  |   |  |
| 10:20 a.m. 5/31 1961  |  |  |  | PENNA. R.R.   |  | Elkton R.D.   |  | Cecil  |  | Maryland  |  |   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |  | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE  |  | R. C. DODSON   |  | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                              |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | DATE SIGNED   |  | May 31, 1961  |  |
| EXAMINER'S NAME (Type)  |  | R. C. DODSON   |  | M.D.  |  | Rising Sun, Maryland  |  |  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or country)  |  | (State)  |  |   |  |   |  |   |  |
| Cremation   |  | June 3, 1961   |  | West Laurel Hill  |  | Bala-Cynwyd, Mont. Co. Pa.  |  |  |  |   |  |   |  |   |  |
| 23. FUNERAL DIRECTOR  |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |   |  |   |  |
| PIPPIN FUNERAL HOME   |  | Elkton, Md.  |  | JUN 2 '61   |  | Arthur L. Kraus   |  |  |  |   |  |   |  |   |  |

100-1001  
100-1001

(M)

(1)

RESEARCH AND REPORT OF DEATH  
MEDICAL EXAMINER  
STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
COUNTY OF LOS ANGELES  
CITY OF LOS ANGELES  
NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE  
SEX  
RACE  
EDUCATION  
OCCUPATION  
MARITAL STATUS  
RELIGION  
BIRTH DATE  
BIRTH PLACE  
PARENTS  
SIBLINGS  
PREVIOUS ILLNESS  
MEDICATION  
ALCOHOL  
TOBACCO  
DRUGS  
OTHER  
FINDINGS  
REMARKS  
SIGNATURE  
DATE

Examination June 2, 1961 Post mortem will be held - June 2, 1961